Conscientious Refusal in Family Medicine Residency Training

Jennifer E. Frank, MD

BACKGROUND AND OBJECTIVES: Conscientious refusal among physicians to provide medical care is known to exist. The prevalence of conscientious refusal in residents and behaviors surrounding moral objections is largely unknown. The purpose of this study was to identify the prevalence of moral objections among family medicine residents and faculty members and to identify beliefs and actions surrounding conscientious refusal.

METHODS: A Web-based survey was e-mailed to residents and faculty in six family medicine residency programs. Those respondents identifying a moral objection were asked about their beliefs and practices regarding disclosure and referral.

RESULTS: A total of 154 physicians responded (44.9% response rate). The majority reported a moral objection to at least one procedure with abortion for gender selection eliciting the largest number of moral objections (79.2%). Of the 14 procedures identified, at least four respondents (2.6%) reported an objection. The majority believed that a physician with a moral objection has a duty to disclose his or her objection to colleagues, but the majority had not done so. Resident and faculty physicians were generally felt to have the same right to refuse. Fifty-five percent of all respondents reported having participated in morally objectionable care based on medical futility.

CONCLUSIONS: This study is the first to demonstrate the prevalence of moral objection to legally available medical procedures among family medicine residents and faculty. The survey responses demonstrate that conscientious objection exists and that there is support for physicians exercising moral objection in clinical practice, provided they engage in appropriate patient education and referral.

Conscience objection, a term most closely associated with opposition to war, exists among health care professionals. Several widely publicized cases in which a physician or pharmacist refused to dispense a medication or perform a procedure for reasons of conscience have brought the issue to national prominence. While conscientious objection in medicine is known to be present, what occurs in the interaction between a physician and patient at the moment a conflict of conscience arises is unknown. Behaviors surrounding conscientious refusal are largely unknown with anecdotal descriptions being the norm, usually in the context of a legal case.

Curlin et al conducted a nationwide survey of a random, stratified sample of US physicians on attitudes and beliefs regarding religious beliefs and conscientious objection. Physicians were predominately male (74%), Caucasian (78%), and came from diverse geographical locations, practice types, and medical and surgical subspecialties. The majority (63%) scored moderate or high on a scale of intrinsic religiosity, with 50% of respondents identifying a Christian affiliation, 16% identifying a Jewish affiliation, 10% identifying no religious affiliation, and the remainder identifying another type of religious affiliation. Fifty-two percent of the physicians surveyed objected to abortion for failed contraception, 42% objected to prescribing birth control to adolescents without parental consent, and 17% objected to terminal sedation. Physicians in this survey were also queried about opinions regarding behaviors when a physician has a conscientious objection. Sixty-three percent of respondents believed it is ethical for the physician to describe his or her objection; 86% believed that the physician has an obligation to refer for the procedure.

A second survey of a random sample of primary care physicians was conducted by Lawrence and Curlin.

From the Department of Family Medicine, University of Wisconsin
In this study, 61% of respondents were male, 44% were Asian, and 44% were Caucasian; they were fairly equally distributed among ages with a range of 26–60 years old, and 26% were family physicians, with the remaining 74% specializing in internal medicine. Interestingly, while 78% of respondents agreed that a physician should never do something he or she considered to be morally wrong, 57% agreed that physicians have an obligation to provide services to which they may morally object. When objections to legal medical procedures were identified, the majority of physicians did not believe they have an obligation to perform the procedure, but the majority did believe they have an obligation to refer. Sixty-eight percent of physicians objected to physician-assisted suicide, 44% objected to abortion for failed contraception, and 44% objected to abortion if the fetus had Down syndrome.

Residency training is a unique practice environment. A power differential exists between faculty and resident physicians potentially impacting a resident physician’s comfort with or ability to articulate a moral opposition to a controversial practice. Practice attitudes and professional roles are still being developed by residents who are in what has been termed a “professional adolescence.” Additionally, resident physicians are required to receive training in a specified group of patient care scenarios and medical procedures, which may make conscientious refusal difficult to reconcile with training requirements.

Research into conscientious objection in residency training is limited. Lazarus described the environment in an obstetrics and gynecology residency program surrounding the performance of or refusal to perform abortions. As has been described elsewhere, residents who declined to participate in abortions for moral reasons chose, in some cases, to extend their refusal to involvement in pre-procedure evaluation, ordering labs, or even interacting with the patient after the patient’s intent to obtain an abortion became known. Interestingly, only six of 20 residents and two of 24 faculty physicians elected to perform abortions in the residency program she describes.

Family medicine residency training provides a unique opportunity to explore the professional, legal, ethical, and practical issues surrounding conscientious objection. Family medicine is distinctive among specialties in encompassing nearly all controversial medical practices, including neonatal male circumcision, reproductive health, sexual medicine, end-of-life care, and transgender medicine. During residency training, resident physicians are both expected and required to practice full-scope family medicine, which includes comprehensive care of patients at all stages of life. While an attending family physician may select a practice that allows him or her to freely exercise his or her moral objections unencumbered, resident physicians do not enjoy the same freedom in choosing how they practice medicine. They are subject to attending oversight and required to participate in clinical activities in which they may be asked to provide a service to which they object. As trainees, their objections to medical procedures considered typical for a family physician to perform may interfere with an adequate training experience or may unfairly burden colleagues with increased workload. This paper reports results of a survey of attending and resident family physicians’ beliefs about conscientious objection and practices when confronting this issue in their own clinical experience.

Methods
Sample
The University of Wisconsin Institutional Review Board determined that this research study was exempt from review. A quantitative study was conducted of resident and faculty physicians in the six family medicine residency programs in the University of Wisconsin Department of Family Medicine from June through August 2008. A total of 343 resident and faculty physicians were invited to participate in an electronic Web-based survey. Three separate invitations were sent by e-mail to resident and faculty physicians with a link to the survey. Demographic information was not collected on study participants in an effort to preserve confidentiality among a relatively small group of physicians.

Survey Instrument
A Web-based survey (websurvey@uw) was used for the eight-item questionnaire. The Web-based survey was anonymous and voluntary, and all questions were optional to complete. The survey focused on prevalence of moral objection to 14 legally available medical procedures, practices, and prescriptions, behaviors and opinions regarding disclosure of moral objections, and beliefs regarding different requirements or allowances for resident physicians to exercise moral objection compared with attending physicians (survey available from corresponding author upon request). The survey questions were based in part on a previously published survey of physicians’ beliefs regarding conscientious objection.

Data Analysis
Descriptive frequency statistics were calculated on responses to each of the questions in the survey. Both absolute numbers of responses and percentages based on the total number of responses to each question were calculated.

Results
Survey Response Rate
A total of 154 respondents completed the survey, yielding an overall response rate of 44.9%. Survey respondents were not identified based on type of response, faculty or resident status, or any demographic data. Since no survey items required mandatory completion, not all questions received 154 responses. Survey questions received between 131 and 154 responses each.
Conscientious Objection to Specific Procedures
Each of the 14 procedures or prescriptions had at least four respondents (2.6%) who reported an objection. One procedure (performing or referring for an abortion for gender selection because of parental preference) solicited 122 respondents who identified a potential objection, representing 79.2% of total respondents. Aside from this one procedure, a minority of respondents (4–43, representing 2.6%–27.9%, respectively) identified an objection to the listed procedures and practices. Likewise, the majority of respondents identified “no objection” to 13 of 14 procedures and practices with a range from 91–147 respondents (59%–95.5%, respectively).

The respondents were also asked to identify whether residents should be allowed to refuse participation in these procedures and practices. With one exception, a larger number of respondents identified that a resident had a right to refuse than the number who volunteered a personal objection. Depending on the procedure, between 19 (12.3%) and 89 (57.8%) of respondents indicated a belief in the resident’s right to refuse, with performing an abortion for failed contraception generating the largest positive responses.

Behaviors Surrounding Conscientious Refusal
Twelve (13%) of the respondents who had at least one moral objection reported notifying their supervisor (medical director or program director) of their objection, with the majority (87%) reporting that they had not informed their supervisor of their objection. However, the majority of respondents (86.4%) believed that a physician with a moral objection was obligated to disclose the objection to practice colleagues. The majority of respondents with a moral objection (62/103 or 60.2%) did report having a plan to “inform, educate, and refer patients who request the objectionable procedure.”

Respondents were asked about their experience providing or refusing to provide care that they considered morally objectionable on the basis that the care was futile. Eighty-four of 147 respondents (57.1%) reported providing this type of care with 35/147 (23.8%) stating they had not done so. Twenty-eight of 147 (19%) reported never being in this specific clinical scenario. Twenty-seven of 151 (17.9%) respondents reported refusing to provide futile care on moral grounds with 91/151 never refusing (60.3%) and 33/151 (21.9%) never being in this clinical situation.

Obligation to Inform and Refer
The majority of respondents stated that a physician has an obligation to fully inform patients about (95.5%) and to refer patients for (90.2%) procedures to which he or she has a moral objection. Seventy percent of respondents felt that it is acceptable for a physician to explain the rationale behind his or her objection to the patient.

Clinical Scenario
Respondents were given a brief clinical scenario (Table 1). The majority of respondents (69.9%) reported that the attending and resident physician have the same right to refuse. Eighteen percent reported that the resident is more entitled to refuse, 5.9% reported the resident is less entitled to refuse, and 5.2% reported that neither physician has the right to refuse to perform the procedure.

Discussion
The majority of respondents report a moral objection to at least one legal medical procedure, although this is an outlier, with the majority of respondents reporting no objection to the remaining 13 procedures listed. This particular procedure (abortion for gender selection for parental preference) may elicit a strong emotional response among physicians who feel that it is an inappropriate reason for abortion. Each procedure listed elicited at the minimum four respondents with a potential objection, revealing that even common and widespread medical treatments and procedures (vasectomy, tubal ligation, treatment of sexual dysfunction in an unmarried person) are objectionable to a small minority of practicing physicians.

In general, there was support for resident refusal even among physicians who did not personally have an objection to a specified procedure or practice. This was further borne out in a hypothetical clinical scenario in which most survey respondents identified that a resident physician has an equal or stronger right to refuse than an attending physician. Despite the reliance on resident physicians to do much of the “front-line” work with patients and the recognition that broad training experiences are needed to become a competent family physician, resident and faculty family physicians do respect resident physicians’ ability to hold

Table 1: Hypothetical Scenario
Consider the following scenario. An attending physician and a second-year resident are rounding in the nursery on one of the residency program’s patients. One of the newborns is scheduled to have a circumcision performed that morning. The resident objects to neonatal circumcision on moral grounds and refuses to participate in the procedure.
- The resident is more entitled to refuse to participate in a morally objectionable procedure because his or her participation is not essential to the patient’s care.
- The resident is less entitled to refuse to participate in a morally objectionable procedure because he or she is a trainee.
- The resident has the same right to refuse to participate as the attending physician does because they are both physicians.
- Neither the resident nor the attending has the right to refuse to participate.
- Other, please specify
personal moral objections and to exercise their right to refuse.

In the presence of moral objections, disclosure to colleagues is seen as an obligation, but it is rarely done. More conversation around conscientious refusal needs to occur at all levels, including between learner and teacher, colleagues, and physicians and patients. Reasons for failure to disclose need to be elucidated to identify barriers. Given the prevalence of moral objections to legal medical procedures and prescriptions, medical students, residents, and faculty should discuss the ethics of conscientious refusal, methods for communication with peers, supervisors, and patients, and the requirement for legally and ethically sound plans of care.

Limitations
The response rate (44.9%) is one limitation of the survey since the majority of those invited to respond did not do so. This limits interpretation of the results and could indicate that those surveyed who had stronger beliefs (in one direction or the other) may have been more likely to respond. The results of this study are unique to the residents and faculty in the University of Wisconsin Department of Family Medicine and limit generalizability of the findings. No demographic data was obtained, making it impossible to determine if professional experience or current position is linked to beliefs or behaviors. It is also not possible to identify if specific characteristics (such as religious beliefs) are associated with moral objections as was identified previously.3

Since behaviors are self-reported, there may be bias inherent in the responses and error in recollection of clinical experiences. The complexity of the subject matter may also limit the respondents’ ability to give a complete answer by requiring a yes or no response.

Conclusions
The appropriate response to the resident physician who voices a moral opposition to a controversial medical practice is still being defined. To promote ethical development in residency education, it is important to proceed through several steps. The first, which this study sought to address, is to define the prevalence of the issue. Clearly, if conscientious refusal is only a philosophical construct that does not play out in the interaction between a patient and physician, then it is not a high priority for resident education. If, however, moral objections to legal, medically appropriate, and available procedures, prescriptions, and practices do exist as demonstrated by this survey and others,3,4 it is imperative that an appropriate response is considered, debated, and finally defined.

Lazarus5 quantified the problem facing resident physicians and program directors who confront moral opposition. In her program, 17/20 residents volunteered that the policy regarding performing abortions was not stated when they interviewed for the program and that the policy should be clarified. Fifteen of the 20 residents desired further discussion on the ethical issues surrounding abortion policy.

While interesting, it is not sufficient to only define the issue. Further steps must explore how beliefs evolve into behaviors, how those behaviors play out in patient care, and how resident physicians can be educated to promote ethical behavior in the provision of care.

Acknowledgments: The author thanks Dr Norman Fost of the Department of Bioethics at the University of Wisconsin School of Medicine and Public Health for assistance in development of the survey instrument and mentorship through the research process. Dr Frank completed the research presented in this paper and wrote the article while a faculty member in the Department of Family Medicine at the University of Wisconsin.

Correspondence: Address correspondence to Dr Frank, Theda Care Physicians, 1380 Tular Road, Neenah, WI 54956; 920-727-3480. jennifer.frank@thedacare.org.

References